BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of:

WILMA ELAINE WALKER
1136 Rose Walk Way
Pasadena, CA 91103

Registered Nurse License No. 417053
Nurse Practitioner License No. NP 17022
Nurse Practitioner Furnisher License No. NPF 17022

Respondent.

Case No. 2008-101

OAH No. L2008010098

DECISION

The attached proposed decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **October 29, 2009.**

IT IS SO ORDERED this **29th** day of **September, 2009**.

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	**Case No. 2008-101**
WILMA ELAINE WALKER	**OAH No. L2008010098**
Registered Nurse No. RN 417053 **Nurse Practitioner License No. NP 17022** **Nurse Practitioner Furnisher License No. NPF 17022**	
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing on January 20, 21, 22, 23, and 26, 2009, and June 11 and 12, 2009, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Ruth Ann Terry, M.P.H., R.N. (Complainant) was represented by Linda L. Sun, Deputy Attorney General.

Wilma Elaine Walker (Respondent) was represented by Jennifer L. Sturges, Attorney at Law.

Oral and documentary evidence was received. The record was held open to and including June 18, 2009, for Respondent to submit one or more declarations in connection with the attempts Respondent had made to locate witness Nevin Powell. The declaration of Robin Y. Solmayor was timely received and was marked as Respondent's Exhibit "M" for identification.

On June 18, 2009, the record was closed, and the matter was deemed submitted for decision.

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On or about June 30, 2009, Complainant filed her Motion to Strike the Testimony of Nevin Powell. As is more fully set forth below, on June 30, 2009, the record was re-opened to and including July 14, 2009, for Respondent to serve and file an Opposition to Complainant's motion. "Respondent, Wilma Walker's "Opposition to Complainant's Motion to Strike Nevin Powell's Testimony; Memorandum of Points and Authorities" was timely received and was marked as Respondent's Exhibit "O" for identification.

On July 14, 2009, the record was closed, and the matter was deemed submitted for decision.

EVIDENTIARY ISSUE—THE TESTIMONY OF WITNESS NEVIN POWELL

1. A Prehearing Conference was held on June 30, 2008, before Administrative Law Judge Mark Harman. Both parties were represented by counsel. Based on communications between Judge Harman and counsel, Judge Harman issued a written Prehearing Conference Order the same day. That Order contained the following language:

> 5. By 5:00 p.m. on July 15, 2008, the parties are to serve each other with final **lists** of their percipient witnesses and exhibits. . . . Copies of the parties' exhibit and witness lists (including both expert and percipient witnesses) are to be sent to Judge Harman at the Office of Administrative Hearings, and shall indicate the date of the hearing.
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> [¶] . . . [¶]
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> Except for good cause shown, impeachment or rebuttal . . . no witness not included in the witness lists may testify at the hearing. (Emphasis in text.)

2. Witness Nevin Powell was not named on Respondent's final witness list.

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3. During the hearing, Respondent attempted to introduce the deposition transcript of witness Nevin Powell, which had been taken in connection with a civil lawsuit. Complainant objected to the use of the transcript on grounds that (1) the transcript constituted hearsay for which no exception applied; (2) no showing was made of witness unavailability; (3) no privity existed between the parties to the civil lawsuit and the parties to the administrative action; and, (4) in offering the transcript, Respondent had failed to comply with the provisions of Government Code section 11514. The Administrative Law Judge ruled that Respondent's expert could testify regarding the transcript as a basis for her opinion(s), but that the transcript was not admissible as independent evidence[1].

4. On June 11, 2009, witness Nevin Powell appeared pursuant to a subpoena from Respondent. Complainant's counsel objected to his being permitted to testify based on the provisions in Judge Harman's Prehearing Conference Order. Respondent's counsel argued that her law firm had been unable to locate Mr. Powell until only recently, after the Administrative Law Judge's ruling on the deposition transcript, and therefore, she had been unable to include Mr. Powell on her witness list. However, an attorney in her office had sent a letter to Complainant's counsel on February 4, 2009, advising counsel that Mr. Powell had been subpoenaed. That letter read in pertinent part:

> This letter will serve as notification that Nevin Powell is under subpoena for June 11, 2009 and will testify live rather than by deposition. We intended to introduce his testimony through the reading of his deposition, but after your objection to the reading of Mr. Powell's deposition, it became necessary for us to subpoena him to provide live testimony.

5. Because he had been provided no evidence of the steps that had been taken to locate Mr. Powell in time for him to be included on Respondent's witness list, the Administrative Law Judge lacked enough information to determine whether good cause existed under the Prehearing Conference Order to permit Mr. Powell to testify. He therefore permitted Mr. Powell to testify subject to a motion to strike[2], and ordered Respondent's counsel to submit a declaration or declarations from the person or persons in her office who had attempted but failed to locate Mr. Powell, describing the efforts that had been made to locate him. The declaration(s) was/were due no later than June 18, 2009.

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[1] Complainant's argument regarding Government Code section 11514 was not well-founded. Government Code section 11514 applies only to affidavits, not deposition transcripts.

[2] Mr. Powell did not testify until the following day, June 12. 2009.

6. On June 17, 2009, the Administrative Law Judge received from Respondent's counsel the "Declaration of Robin Y. Solmayor, Esq. re: Nevin Powell" in compliance with the Administrative Law Judge's Order. Accompanying that document was the "Declaration of Jennifer L. Sturges." Ms. Sturges's declaration did not describe any efforts made at locating Mr. Powell, but instead contained additional argument.

7. The record was closed on June 18, 2009, and the matter was deemed submitted for decision.

8. Further argument on the issue of Mr. Powell's testimony had not been requested by the Administrative Law Judge. Therefore, Ms. Sturges' declaration was improper under the terms of the Prehearing Conference Order and the Order of the trial judge. As such, the Administrative Law Judge did not intend to mark Ms. Sturges's declaration for identification. However, On June 30, 2009, the Administrative Law Judge received Complainant's "Motion to Strike Nevin Powell's Testimony," which argued the merits of Respondent's position on that issue, criticized a number of aspects of Ms. Solmayor's declaration, and contained the declaration of Katherine Messana, who claimed to have easily located addresses and telephone numbers for Mr. Powell with only 30 minutes of work on the Internet. Complainant's motion rendered Ms. Sturges's declaration relevant.

9. In her opposition to Complainant's Motion to Strike Nevin Powell's Testimony, Respondent makes three arguments: (1) Mr. Powell's testimony is admissible pursuant to Government Code section 11513, subdivision (c); (2) Complainant failed to show that the information about Mr. Powell found on the Internet in June of 2009 was also there when Respondent's counsel looked for it in 2008; and (3) Mr. Powell's testimony was admissible as rebuttal evidence and therefore, Respondent was not required to name him on her witness list.

10. Government Code section 11513, subdivision (c), states:

> The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.

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11. Respondent's counsel begins her analysis by correctly pointing out that the purpose of an administrative proceeding such as the case *sub judice* is to protect the public. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Clerici v. Department of Motor Vehicles* (1990) 224 Cal.App.3d 1015, 1029; *Handeland v. Department of Real Estate* (1976) 58 Cal.App.3d 513, 518; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) She then argues that, because Mr. Powell's testimony was relevant, the spirit of the administrative hearing process should be respected by admitting Mr. Powell's testimony pursuant to Government Code section 11513, subdivision (c). At page 4, lines 18-26 of her opposition, Respondent's counsel argues:

> **[A]ny relevant evidence *should* be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.** Based upon the legislative intent of the administrative process, Complainant's movement to strike Mr. Powell's testimony runs contrary to that clear legislative intent of the administrative law process. If Complainant was adhering to the spirit of the administrative law process, it [*sic*] would have encouraged the admission of Mr. Powell's testimony, as the same should be considered in its truth-finding mission to determine if Respondent poses a risk to the public. (Emphasis in text.)

12. Respondent's argument is disingenuous. During the seven days of hearing, Respondent's counsel raised an extraordinary number of objections to Complainant's evidence, most of which were not grounded on relevance. Those objections included, but were far from limited to, an adamant and lengthy argument to prohibit one of Complainant's experts from testifying at the hearing. So numerous and extended were the objections and arguments of Respondent's counsel that they materially contributed to the necessity of adding two hearing days to the hearing originally scheduled for five days. Had Respondent's counsel actually believed that the evidence should be based solely on Government Code section 11513, subdivision (c), surely there would have been far fewer objections, and almost all of them, if not all of them, would be based on relevance. By her argument, Respondent is essentially asking the Administrative Law Judge to change the rules under which the hearing was held, after the close of the evidence. Such an inequitable result is unacceptable.

13. Further, in making her argument, Respondent ignores the fact that an administrative law judge had ordered witnesses disclosed by a date certain. A Prehearing Conference Order of an Administrative Law Judge, issued in a proceeding before the Office of Administrative Hearings, is neither a suggestion nor a recommendation. It is an order. Government Code section 11513, subdivision (c) does not grant permission to disobey such an order, and those who choose to disobey such an order do so at their own peril.

14. Respondent could have avoided this problem by naming Mr. Powell on her witness list with an indication that he had not yet been located. This would have enabled Complainant to attempt to locate him if she was so inclined, and may have enabled Respondent to call Mr. Powell as a witness if she located him after the due date for the witness lists.

15. Respondent's first argument is rejected.

16. With respect to Respondent's second argument, it is true that Complainant did not establish that the information regarding Mr. Powell found on the Internet in 2009 was also there in 2008. However, during his testimony at the administrative hearing, Mr. Powell testified that, between July 27, 2005, when his deposition was taken, and June 12, 2009, the day of his testimony at the administrative hearing, he had not moved his residence, changed his telephone number, or changed jobs. Therefore, a reasonable inference may be raised that he could be as easily located in 2008 as he was in 2009. If nothing else, Respondent's counsel could have telephoned the attorney who took Mr. Powell's deposition in the civil action, and requested Mr. Powell's address and telephone number[3].

17. In her declaration, Ms. Solmayor speaks in generalities of actions taken by at least one other individual in her law office to locate Mr. Powell in 2008. The generalities do not satisfy the Administrative Law Judge's order that the specific steps taken be set out by the individuals who took those steps. The weakness of the evidence presented in the Solmayor declaration and the inferences raised by Mr. Powell's testimony, coupled with the Messana declaration, lead to a finding that Respondent made an insufficient effort to locate Mr. Powell in 2008 to justify a finding of "good cause" to admit Mr. Powell's testimony under that portion of Judge Harman's Prehearing Conference Order.

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[3] Mr. Powell testified that he was notified of his deposition by both telephone and letter.

18. Finally, Respondent argues that Mr. Powell's testimony is admissible as rebuttal evidence. She argues:

> Nevin Powell's testimony directly contradicts the evidence provided by the Complainant regarding the significant alarm system issues and timing of the decedent's Code. Complainant's technician testified that the volume on Mr. Nelson's alarm could be heard if that person was at [the patient's] bedside. Mr. Powell testified that he was at [the patient's] bedside, and yet, he did [not] hear the alarm as indicated by the technician. From this evidence there can be two conclusions: 1) if the technician is to be believed, then the alarm was not sounding for the significant time alleged by the Complainant, and thus, decedent was not coding until he was seen by the Asian physician who entered his room subsequent to Mr. Powell's departure, or 2) the alarm system was malfunctioning, and thus, the alarm was not sounding and the lights were not flashing, and thus, there was no way for Respondent to know that Mr. [N . . .][[4]] was coding. Either way, Mr. Powell's testimony is offered to disprove the evidence offered in Complainant's case in chief and goes to the heart of the allegations made by Complainant against Respondent. Therefore, as a rebuttal witness, his identification was not necessary on the witness list provided by Respondent prior to the hearing. (Exhibit O, page 6, lines 14-27.)

19. To the extent that Mr. Powell's testimony is offered only as argued by counsel in the above quote, she is correct. His testimony is admitted for purposes of rebuttal only. Complainant is not prejudiced by the admission of his testimony in that Mr. Powell gave substantially similar testimony in his deposition taken in the civil action, and Respondent listed the transcript of that deposition on her exhibit list.

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[4] The patients' initials are used in this Decision in lieu of their names in order to protect their privacy.

20. However, although Mr. Powell's testimony is received as rebuttal evidence, it does not rebut Complainant's evidence, and therefore, the two conclusions raised in Respondent's argument are not established. Mr. Powell did not testify that the alarm did not sound or that lights on the monitor did not flash. He testified that he did not hear an alarm or see flashing lights. He further testified that he was not focused on the monitor, but was focused solely on his friend, who was lying in a hospital bed with a tube in his mouth, his arms in restraints, and "tubes all over the place." He held the patient's hand and prayed. Mr. Powell testified that he did not see or hear any beeps, tones or noises in or out of the patient's room. However, the evidence established that there were a number of machines, both in and out of the patient's room[5], that were capable of making a variety of noises.[6]

21. In summary, Complainant's Motion to Strike Nevin Powell's Testimony denied. The testimony is admitted solely as rebuttal evidence. However, it is given little weight because it does not establish that the alarm was not activated during his visit with the patient. It establishes only that he did not notice it (or any other noise-making device), an understandable occurrence given his solemn purpose and focus on that day.[7]

FACTUAL FINDINGS

The Administrative Law Judge makes the following factual findings:

1. The First Amended Accusation was made by Ruth Ann Terry, M.P.H., R.N., Complainant, who was then the Executive Officer, Board of Registered Nursing, Department of Consumer Affairs, State of California, acting in her official capacity.

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[5] For example, the ventilator and the IV pump produced audible sounds. Both machines were in the patient's room.

[6] Mr. Powell's testimony that a flashing red light would be bright enough to catch his attention, and that he would not have paid attention to blinking numbers on the monitor was speculative, and is given no weight

[7] Apparently, it is not difficult to "tune out" the alarms. The evidence established that numerous alarms were triggered throughout Respondent's shift on the day at issue. However, even Respondent, a trained registered nurse serving as a charge nurse on the day of the incident, testified that she did not recall if she heard any alarms coming from either the patient's room or from the central monitor during her shift. Respondent had been on duty for approximately 8.5 hours at the time the Code Blue was called.

Respondent's Background

2. On January 1, 1987, Respondent was issued registered nurse license number RN 417053 by the Board of Registered Nursing (Board). The license was in full force and effect at all relevant times. It was scheduled to expire on May 31, 2009, unless renewed. The evidence did not disclose whether the license has been renewed. However, if it has not, the Board maintains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b). On November 21, 2006, the Board issued to Respondent nurse practitioner certification number 17022, and on October 15, 2008, the Board issued to Respondent nurse practitioner furnishing certification number 17022. Like her registered nurse license, both certifications were due to expire on May 31, 2009, unless renewed. Respondent's license has never before been subject to discipline.

3. Respondent received an Associate of Science in Nursing degree in 1987, a Bachelor of Science in Nursing (BSN) degree in 1998, and a Master of Science in Nursing --Family Nurse Practitioner degree in 2006. She was the recipient of an Advanced Education Nursing Traineeship from the Department of Health and Human Services in 2005-2006, and the Frederick Douglass and Mary McLeod Bethune Award from California State University Dominguez Hills in 2006. In addition to serving as a nurse and nurse practitioner, Respondent has served on the adjunct faculty for the BSN program at Mount St. Mary's College, as a Vocational Nurse Clinical Instructor at the College of Nursing and Technology, and as a Registered Nurse Clinical Preceptor for Los Angeles County, King/Drew Medical Center. She holds certifications from the American Academy of Nurse Practitioners and the American Association of Critical Care Nurses (CCRN). She is certified in Basic Cardiac Life Support, Advanced Cardiovascular Life Support and Pediatric Advanced Life Support. Respondent enjoys a very good reputation in the nursing community as a competent and caring nurse.

4. Respondent has been steadily employed as a registered nurse since 1987. From 1991, until the time of her discharge in 2005, she was employed at Los Angeles County, King/Drew Medical Center (MLK). She became a charge nurse in the MLK Intensive Care Unit (ICU) in 1994. The two incidents addressed in this action occurred during the course of Respondent's employment as a critical care nurse in the ICU at MLK.

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Patient W.W.

5. In February 2004, Respondent was assigned to care for W.W. who had been admitted to MLK with a diagnosis of "Rule Out Meningitis, Poly Substance Abuse." In the course of W.W.'s hospitalization, the hospital pharmacy issued a daily Medication Administration Record (MAR). Between February 12, 2004, and February 17, 2004, the pharmacy erroneously listed Imatinib Mesylate (brand name, Gleevec) to be given daily in four 100 mg doses. Gleevec is a medication indicated for the treatment of cancer. It is not indicated for meningitis.

6. Proper protocol and the standard of care required that a nurse administering any medication listed on an MAR verify its use against the physician's order before administering it to the patient. On February 12, 2004 and February 13, 2004, some of the nurses assigned to W.W.'s care did so, thereby discovering the pharmacy's error. Those nurses did not administer the drug to W.W. Respondent was assigned to W.W.'s care on February 17, 2004. She did not verify the MAR against the physician's order, and she administered Gleevec to the patient.

7. At the administrative hearing, Respondent admitted that, on February 17, 2004, she did not know the indications for Gleevec.

8. Each MAR contained a column entitled "Verify Order and Initial." Nurses were required to write their initials in that column next to the name of each medication they verified against the physician's order. If they administered the medication after verifying it, they were required to write the time of administration and their initials in other columns on the MAR.

9. Respondent admits that she failed to verify the use of Gleevec against the physician's order. She also admits that she initialed the MAR indicating that she administered Gleevec to W.W. at 10:00 a.m. on February 17, 2004. However, she denies that the initials appearing in the verification column are hers. According to the February 17, 2004 MAR, Respondent administered 22 different medications to W.W. on that day (some on more than one occasion). For each of those medications, the initials in the verification column appear to be a "W," but the initials in the column indicating that Respondent administered the medication read "WEW." At the administrative hearing, Respondent testified that she signs her initials "WEW," but that, depending on how much she is required to write, they occasionally appear as a "W." In the case of the February 17, 2004 MAR, either Respondent initialed the verification column indicating that she had checked each of the 22 medications against the physicians' orders, or someone else verified the medications (22 times), possibly using Respondent's initial, even though Respondent was the nurse who administered the medications.

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10. If Respondent initialed the verification column for Gleevec without verifying the medication against the physician's order (which she admitted), her initials in the verification column constitute a falsification of a hospital record. If someone else initialed the verification column, by initialing the administration column (which she did), Respondent adopted the representation that she had first verified the medication against the physician's order. That too constituted a falsification of a hospital record. Either way, Complainant established the second cause for discipline by clear and convincing evidence.

11. Complainant's expert, Laura Sarff, credibly testified that Respondent's conduct with respect to W.W. constituted gross negligence, incompetence, and falsification of hospital records.

12. Respondent's expert, Bernadette Martin, testified that Respondent's administration of Gleevec to W.W. did not constitute gross negligence because nurses rely on MARs, and because Respondent's error occurred only once. That testimony was not persuasive. As indicated above, the MAR form contained a specific column that nurses were required to initial to show they had verified the medications on the MAR against the physicians' orders. In addition, contrary to Ms. Martin's testimony, a finding of gross negligence does not require more than one negligent act. (Cal. Code Regs., tit. 16, §1442.)

13. Respondent's expert also made the following concessions in her testimony: (1) A nurse must document after he/she performs an act. Falsification of records is below the standard of practice and violates hospital policy. It constitutes incompetence and calls into question the nurse's ability to practice. (2) The standard of practice requires a nurse to understand the indications of medications she administers. If she does not, she must look it up. (3) The standard of practice requires both a nurse and the pharmacy to verify a medication against the physician's order. However, the failure of the pharmacy to do so does not excuse the nurse from his/her responsibility. (4) Nurses are required to follow physicians' orders. Respondent failed to do so. (5) Respondent should have known that administering Gleevec to W.W. could compromise his health and life. (6) By administering Gleevec to a patient who was not diagnosed with cancer, Respondent did not satisfy the definition of competence. (Bus. & Prof. Code. §2761; Cal. Code Regs., tit. 16, §1443.5.) Nurses are taught the "five R's" in nursing school: right drug, right patient, right time, right dose, and right route." By administering Gleevec to W.W., Respondent violated two of the five R's and was incompetent. The above concessions, made by Respondent's expert, belie her testimony that Respondent did not commit gross negligence in administering Gleevec to W.W.

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14. Respondent and her expert testified that W.W.'s medical record may have been "thinned," a procedure performed by hospital personnel when the chart becomes too thick. Certain documents are removed and placed in storage, and notations are made on the front of the chart indicating the removal of documents and the date of their removal. If W.W.'s chart had been thinned, and the physician's order had been removed, she was justified in relying on earlier MARs which indicated that Gleevec had been administered by other nurses. That testimony was not convincing for the following reasons: (1) Respondent bore the burden of proving that W.W.'s chart had been thinned. (Evid. Code §500.) The testimony on that issue was speculative and did not establish its truth. (2) Consistent with the testimony of Complainant's expert, relying on an earlier MAR reflecting the erroneous administration of a controlled substance without verifying it against a physician's order only perpetuates the error. The standard of care requires verification against the physician's order. If the order is not in the chart, the nurse must locate it rather than rely on an erroneous MAR.

15. Respondent's administration of Gleevec, an anti-cancer chemotherapy agent, to a patient who was not diagnosed with cancer, constituted gross negligence and incompetence.

16. Respondent's failure to verify the MAR's reference to Gleevec against the physician's order, and her administration of an incorrect medication to a patient, constitutes gross negligence.

17. Respondent's misrepresentation that she verified the use of Gleevec against the physician's order, as reflected on the MAR, constitutes a falsification of a hospital record.

Patient M.N.

18. On October 7, 2004, Respondent was assigned to serve as the charge nurse in the MLK ICU. Another nurse in the unit called in sick was not replaced. Instead, Respondent was assigned to care for two patients on the unit in addition to serving as charge nurse. She was due at work at 7:00 a.m. She arrived at 8:00.

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19. One of the patients to whom Respondent was assigned was M.N., a male patient who had been admitted to MLK with diagnoses of AIDS, pneumonia, bilateral pneumothorax[8] and Adult Respiratory Distress Syndrome (ARDS). Respondent's other patient was in the room next to M.N.'s. After taking report from the nurse going off duty[9], Respondent documented that she had checked M.N.'s soft restraints at 7:15, 7:30 and 7:45, even though she had not been on the unit at those times. At the administrative hearing, she and her expert maintained that it was proper for her to have done so because the nurse going off duty had told her the restraints had been checked. Therefore, it was tantamount to two nurses documenting the same thing. However, Respondent's expert also conceded that a nurse on duty must continue to document the record until the next nurse arrives, even if the next nurse is late. As explained by Complainant's expert and conceded by Respondent's expert (see Finding 13), they are incorrect. The purpose of documentation is to create a record of what was done and by whom it was done. A nurse who documents that he/she performed an act that was actually performed by another nurse obviates that purpose as well as the trust instilled in medical records by medical professionals and the public at large. Respondent's misrepresentation that she checked M.N.'s restraints three times before she arrived on the unit constitutes falsification of a hospital record pursuant to Business and Professions Code[10] section 2162, subdivision (e)[11].

20. Several electronic devices were connected to M.N., including an oxygen sensor, a non-invasive blood pressure cuff, a peripheral attached to an IV infusion pump, a ventilator, and a cardiac monitor. In addition to the soft restraints, M.N. wore a mitten to prevent him from grasping at medical equipment. Some of the equipment, such as the cardiac monitor, ventilator, and IV pump, was capable of emitting audible signals.

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[8] The presence of free air or gas in the pleural cavity surrounding the lungs.

[9] Respondent received two reports, one specifically for the two patients for whom she was to care, and one for the other patients in the ICU whose care Respondent would supervise as the charge nurse on the incoming shift.

[10] All statutory references are to the Business and Professions Code unless otherwise indicated.

[11] Respondent is not charged in the First Amended Accusation with falsification of M.N.'s hospital record. Therefore, this finding cannot be used as a cause for discipline of her registered nurse license. However, it can be, and is, used as a factor in aggravation in determining the nature and level of discipline to be imposed as a result of cause existing to discipline the license for gross negligence and incompetence in connection with both patients, and falsification of a hospital record in connection with patient W.W.

21. The cardiac monitor emitted both audible and visual signals when an alarm was triggered. Those signals were audible and visible on the monitor in the patient's room and on a separate monitor located at the central nurses' station in the ICU[12]. The sounds emitted by the IV pump and the ventilator emanated only from the machines in the patient's room. Certain events triggered either a yellow alert or a red alert on the cardiac monitor. A yellow alert was an urgent situation, but would clear itself when the event that triggered it resolved. A red alert was an emergent situation that could be cleared only by hospital personnel manually canceling it on the monitor at the bedside. The visual alert flashed even when the volume on the auditory alert was turned down.

22. Critical care nurses at MLK were regularly trained in the proper use of the cardiac monitor. That training included, among other things, setting parameters, checking alarms, canceling alarms, printing strips, and checking for and setting appropriate alarm volume. Respondent's personnel file contains several indications that, for at least five years, she had been trained and found competent in the use of the cardiac monitor. A user's manual was attached to each cardiac monitor in the ICU at MLK, and two additional manuals were kept within the unit. The manuals contained a section on how to adjust the volume of the alarms. Nurses were required to know how to adjust the alarm volume on the monitor.

23. MLK had implemented appropriate policies regarding the use of the cardiac monitor and other electronic equipment well before October 7, 2004.

24. Respondent used the same model cardiac monitor as was at M.N.'s bedside most of the time she worked at MLK. Her claim that she did not recall the policy for the cardiac monitor being in place, or having signed off on the policy indicating she had received the necessary instruction, was not credible in that Respondent's being assigned by MLK to serve as a charge nurse in its ICU from 1994 to 2004, without being knowledgeable regarding the policies governing the ICU, defies both logic and reason. Her great familiarity with the machine based on hands-on experience for approximately 10 years, also belies her testimony.

25. In the event of an equipment failure, nurses were required to remove the faulty equipment from the patient care area, mark it, and notify the Bio-Medical Department.

26. The cardiac monitor measured a patient's vital signs. Because M.N. did not have an arterial line, the monitor was set to measure his blood pressure automatically at two-hour intervals. The blood pressure measurement then remained constant on the monitor until the next measurement two hours later. However, other vital signs (heart rate, respiration, and oxygen saturation) were measured in real time.

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[12] On October 7, 2004, no one was assigned by MLK to observe the monitors at the central nurses' station.

27. Upon assuming care of patient M.N., Respondent performed a head-to-toe assessment and charted the assessment. She also checked the parameters on the cardiac monitor and ventilator. She set the parameters on the cardiac monitor so that it would trigger an alarm if M.N.'s heart rate decreased below 50 beats per minute and/or if his oxygen saturation fell below 90 percent[13]. Respondent did not check the volume setting for the alarms on the monitor. At the administrative hearing, she denied knowing, in October 2004, that the volume could be adjusted. That testimony was not credible based on her several trainings on the monitor's use, her being found competent in its use on several occasions, her position as an experienced charge nurse in the MLK ICU, the fact that she had worked at MLK for approximately 11 years using the same model monitor most of that time, and the placement of the user's manuals at the location of each monitor on the unit.

28. Upon completion of her assessment, Respondent stationed herself at a counter outside her two patients' rooms and approximately 12-20 feet from the door of M.N.'s room. From that position, Respondent could see the door but could not see M.N. The cardiac monitor in M.N.'s room was located near the head of the bed.

29. M.N.'s status throughout Respondent's shift on October 7, 2004, was marked by tachycardia[14], tachypnea[15], and agitation. Those conditions resulted in the cardiac monitor triggering several codes during that day, most of which were yellow alarms. A red alarm was triggered at approximately 1130. Respondent was in the patient's room at that time administering Haldol in accordance with a physician's order. She cancelled the red alarm on the cardiac monitor. Respondent does not recall hearing the IV pump, ventilator or cardiac monitor emit any sound, either in M.N.'s room or at the central nurses' station, at any time during her October 7, 2004 shift[16], including the time during the 1130 red alarm.

30. Various medical personnel, including physicians and respiratory therapists, entered and exited M.N.'s room during Respondent's shift. However, they were not present when the red alert was triggered at 1130. Although yellow alerts were triggered throughout the day, the evidence did not disclose whether those individuals heard or noticed them, or if the yellow alerts cleared themselves while those individuals were present.

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[13] Respondent does not recall if she set those parameters or if she checked them and found them already set at those levels.

[14] Rapid heart rate over 90-100 beats per minute.

[15] Rapid breathing over 20 respirations per minute.

[16] As indicated above, only the monitor alarm would sound at the central nurses' station. The other machines did not.

31. Several events took place between 1119 and 1220 that required intervention by Respondent. Most of those events involved M.N.'s elevated respiration rate (between 29 and 39) and decreased oxygen saturation (between 78 and 89 percent). Various notations in her nurse's notes indicate that Respondent had the appropriate physicians notified and administered medication as ordered during that time period. However, those actions were taken exclusive of the alarms that were triggered but were inaudible to Respondent or anyone else.

32. Despite the actions referenced in the above paragraph, Respondent failed to address the cause of M.N.'s agitation and his declining oxygen saturation, and she failed to notify his physicians of the trends. She also failed to address and follow-up on the abnormal laboratory results that had come in on the shift before hers.

33. Respondent performed another head-to-toe assessment at 1600. M.N.'s heart tracing continued to show sinus tachycardia. Breath sound had crackle indicative of the pneumonia and ARDS with which he had been diagnosed. M.N. was hypoxic with oxygen saturation in the low 90's. Respondent suctioned him at the time she performed the assessment.

34. At 1610, Dr. Chiou, an intern on the medical team caring for M.N., ordered an increase in PEEP (positive end-expiratory pressure) to improve M.N.'s oxygen saturation. That order could be carried out only by a respiratory therapist. Respondent does not know, and the evidence did not disclose, whether that order was carried out.

35. Between 1600 and 1630, M.N. was awake and alert, but still agitated. At approximately 1610, Respondent was notified by a security guard that M.N. had a visitor. Before the visitor, Nevin Powell, was allowed in, Respondent changed M.N.'s hospital gown and made him more presentable. During that process, she glanced at the monitor but did not see any flashing lights. Respondent returned to her station, and Mr. Powell was allowed in at approximately 1620. He stayed in M.N.'s room approximately five minutes. During that time, he held M.N.'s hand and prayed. While he was in the room, Mr. Powell did not notice any noise from any of the electronic machines in M.N.'s room, and he did not notice any flashing lights. However, he was focused solely on M.N. during the visit, and not on the monitor or any lights or sounds within the room. Accordingly, Mr. Powell's testimony that he did not see or hear an alarm while he was in M.N.'s room is given little weight.

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36. Upon leaving M.N.'s room, Mr. Powell approached Respondent and spoke with her briefly. During that brief conversation, Dr. Chiou, who had been seated in the ICU, walked toward M.N.'s room. When she reached it, she suddenly called out for help, yelling, "Oh my God, I need help in here" or words of that nature. Respondent went to M.N.'s room and immediately recognized an emergent situation. M.N. was in "imminent danger." (Respondent's term.) Respondent does not recall seeing or hearing an alarm. She immediately left the room to get the crash cart and called to a clerk to page the medical team's third year resident "stat."[17] A Code Blue was called at 1633, but it was unsuccessful. At 1635, the monitor was unable to detect a blood pressure. M.N. died at 1709.

37. After the Code Blue was called off, Dr. Chiou told Respondent she had not heard the monitor's alarm when she discovered M.N. coding. She instructed Respondent to report the problem with the monitor. Respondent failed to comply with Dr. Chiou's order. On direct examination at the administrative hearing, Respondent explained that she failed to do so because she was too busy, and because she was not convinced that the monitor alarm was inaudible. On cross-examination, she stated that she did not report the problem because she was unable to focus on that issue due to her being somewhat shaken by her patient's death; the presence of the patient's mother who had entered the ICU before she was told of her son's death; the presence of another visitor (presumably Powell); and the necessity of caring for her other patient. While the two versions are not mutually exclusive, they are sufficiently disparate to raise questions as to Respondent's credibility on this issue.

38. Respondent's failure to check and ensure proper volume on the cardiac monitor constituted gross negligence and incompetence, as defined in California Code of Regulations, title 16, sections 1442 and 1443, respectively, in that patient harm is foreseeable if a nurse is unable to know when an alarm on the monitor is triggered.[18]

39. Respondent also failed to report M.N.'s death to the nurse supervisor and failed to write an incident report regarding the monitor or the patient's death per hospital protocol.

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[17] "Stat" is an abbreviation for the Latin word, "Statim" meaning "at once" or "immediately." (Stedman's Medical Dict. (27th ed. 2000) p. 1692.)

[18] Complainant's expert witness, Laura Sarff, testified that a CCRN and a charge nurse are held to a higher standard than other nurses because of their higher competence and responsibility and, at least in Respondent's case, because they serve as a mentor to other nurses. Ms. Sarff did not offer a basis for that opinion, and it is therefore given little weight. Nonetheless, even if two standards do exist, Respondent failed to meet the threshold for nurses who are neither charge nurses nor CCRNs. The standard of care from which she deviated was that for all nurses, not only CCRNs and charge nurses.

40. Respondent completed her charting for M.N. and the other patient in her charge at or near the end of her shift. She mistakenly wrote the other patient's information on Respondent's flow sheet in the 1800 column. Upon realizing her mistake, she drew a line through the entries and wrote "error." The evidence did not establish that Respondent tried to falsify M.N.'s medical record by her entries in the 1800 column of his flow sheet.

41. As a result of Respondent's failure to report a problem with the monitor's alarm, another patient was placed on the monitor. A different nurse was assigned to care for that patient. Respondent's failure to notify appropriate personnel about the volume of the monitor alarm following M.N.'s death constituted gross negligence and incompetence, as defined in California Code of Regulations, title 16, sections 1442 and 1443, respectively, in that it placed the new patient at risk of suffering the same fate as did M.N. since the volume on the monitor was almost inaudible, even at the bedside, at all times the monitor was tracking the new patient.

42. The cardiac monitor stores data for only 24 hours. Therefore, when it is in use, new data constantly replaces data that was stored 24 hours earlier. Accordingly, hospital personnel were able to retrieve only a limited amount of data regarding M.N. That data ran from 1100 to the time of his death at 1709 on October 7, 2004. In addition to the numerous yellow alarms and the two red alarms on that day, it showed M.N.'s heart rate immediately prior to and during the Code Blue as follows:

1613-Extreme tachycardia (>145)
1623-Heart rate = 39
1625-Heart rate = 30
1629-Heart rate = 30
1640-Asystole (no heart rate)

43. The red alarm was triggered at all of the above times. No one heard it.

44. On October 8, 2004, the day after M.N.'s death, Dr. Chiou contacted Respondent's supervisor, Cecilia Duckworth, a Supervisor Staff Nurse. Dr. Chiou expressed her concerns about the monitor to Ms. Duckworth. Ms. Duckworth found the monitor connected to the new patient and ordered that patient moved to a different bed. At Ms. Duckworth's request, a hospital electronics technician then tested the cardiac monitor. He found the monitor to be operating normally. However, the alarm volume was set at 15 in a range of 1-165. The alarm was audible at the head of the bed but was faint at the foot of the bed. It was not audible at all outside of M.N.'s room. The technician turned the volume to 95, and the alarm could be clearly heard outside the room.

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45. Ms. Duckworth asked Respondent about the monitor. Respondent told her that the alarm had sounded when M.N. coded, and that nothing was wrong with it. Respondent stated that she had not filed an incident report on either the monitor or M.N.'s death because she had been busy. She also told Ms. Duckworth that an incident report on the death was not necessary because the death had occurred in the patient's room following the normal course of his disease.

46. Respondent's expert, Bernadette Martin, testified that Respondent was neither incompetent nor grossly negligent in her care of M.N., opining that Respondent performed "on a reasonably competent level." However, she conceded that a red alarm is "pretty significant." Although Ms. Martin testified that the standard of care did not require a nurse to check the volume of the cardiac monitor alarm, she stated that an alarm check means that the alarms are on and audible. However, she failed to explain how a nurse performing an alarm check can know the alarms are audible if he/she does not check the volume.

47. On cross-examination, Ms. Martin became progressively less credible. For example, she opined that it is not necessarily an extreme departure from the standard of care for a nurse to misrepresent the true condition of a patient. She stated that, even though the standard of care requires a nurse to be able to hear a cardiac monitor alarm, he/she is not required to check on the volume. Instead, he/she relies on the manufacturer's default settings. That is because the nurse stays close to her patient and can see the monitor. Ms. Martin failed to take into account the fact that the manufacturer cannot anticipate the noise levels at each location where its monitors will be used, and therefore provides a volume adjustment for hospital personnel to use in accordance with their needs. Ms. Martin also failed to take into account the facts of this case. Although Respondent was 12-20 feet from M.N.'s room when the afternoon red alarm was triggered, she was unable to see the monitor from her location. Had she not been in M.N.'s room at the time of the 1130 red alarm, the patient may have died a few hours before he did. When interrogated further, Ms. Martin testified that she was unable to answer whether a nurse must know how to adjust the volume on a cardiac monitor alarm because of the "many other things involved with patient care." Although Ms. Martin did opine that a nurse must be able to hear an alarm, she failed to explain how the nurse is expected to do so if the manufacturer's default setting is too low to make the alarm audible at the nurse's location. She testified that, when checking the monitor every two hours, a nurse should ensure that the alarm is audible. She did not explain how the nurse is to do so without checking the alarm volume, and she did not explain how Respondent met the standard of care even though she failed to check to ensure the alarm was audible every two hours.

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48. Ms. Martin testified that a nurse must report malfunctioning equipment or delegate that task, but she did not believe it was necessarily the standard of practice to do so. She stated that Respondent should have known that patient safety could be jeopardized by her failure to comply with Dr. Chiou's order to report the malfunctioning monitor after M.N.'s death, but that Respondent's conduct in that regard did not constitute gross negligence. She did not offer a basis for that testimony. In light of the obvious harm that can befall a patient who is placed on malfunctioning equipment, Ms. Martin's testimony was not persuasive.

49. At the administrative hearing, Respondent credibly explained that a patient in M.N.'s condition, with oxygen saturation in the low 90's, can suffer respiratory arrest, tire from the effort of breathing, and lose his/her heart rate quickly, resulting in the patient's death. In light of that testimony, it was crucial for Respondent to ensure that the monitor was operating properly and that the alarms could be both seen and heard from her work station in order to maximize the chances of saving M.N. in the event of a respiratory arrest. Respondent failed to do so.

50. Respondent's failure to recognize the abnormal recorded events of patient M.N. during her shift constituted gross negligence and incompetence as defined in California Code of Regulations, title 16, sections 1442 and 1443, respectively.

The Future

51. Respondent admits she gave a critically ill patient the wrong medication. She admits she did not adjust the alarm volume on a cardiac monitor of another patient, and that she did not hear the alarm that triggered a Code Blue which the patient did not survive. However, she is convinced she did nothing wrong with respect to either patient. She showed no remorse at the administrative hearing, and took no responsibility for her wrongdoing. She did not offer any plan to ensure against recurrences.

Costs

52. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board $33,083.25 for its costs of investigation and prosecution of the case. The costs consist of $7,758.50 for investigative services, $375 in expert witness fees, $24,267 in Attorney General's fees and $682.75 for Legal Assistant fees. Those costs are deemed just and reasonable.

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53. Although Complainant proved gross negligence and incompetence with respect to both patients, she did not prove that Respondent pre-documented M.N.'s record in the 1800 column, or that Respondent's charting of M.N.'s vital signs was inconsistent with the recorded events on the cardiac monitor, as alleged in the First Amended Accusation. The investigation and the Deputy Attorney General's trial preparation regarding those allegations were part and parcel of the overall investigation into Respondent's care of M.N. and the trial preparation for the entire case. Therefore, no setoff of costs is warranted for the unproven allegations.

LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following legal conclusions:

1. Cause exists to revoke or suspend registered nurse license number RN 417053, nurse practitioner certification number 17022, and nurse practitioner furnishing certification number 17022, issued to Respondent, Wilma Elaine Walker, pursuant to Business and Professions Code section 2761, subdivision (a)(1), within the meaning of California Code of Regulations, title 16, sections 1443 and 1443.5, for unprofessional conduct involving incompetence, as set forth in Findings 5 through 15, inclusive, and 18 through 50, inclusive.

2. Cause exists to revoke or suspend registered nurse license number RN 417053, nurse practitioner certification number 17022, and nurse practitioner furnishing certification number 17022, issued to Respondent, Wilma Elaine Walker, pursuant to Business and Professions Code section 2761, subdivision (a)(1), within the meaning of California Code of Regulations, title 16, section 1442, for unprofessional conduct involving gross negligence, as set forth in Findings 5 through 16, inclusive, and 18 through 50, inclusive.

3. Cause exists to revoke or suspend registered nurse license number RN 417053, nurse practitioner certification number 17022, and nurse practitioner furnishing certification number 17022, issued to Respondent, Wilma Elaine Walker, pursuant to Business and Professions Code sections 2761, subdivision (a), and 2762, subdivision (e), for unprofessional conduct involving her falsification of hospital records, as set forth in Findings 5 through 14, inclusive, and 17.

4. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Findings 52 and 53.

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5. In *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215 [6 Cal.Rptr.2d 900], the Court stated:

> It is . . . established that a nurse's conduct must not be measured by the standard of care required of a physician or surgeon, but by that of other nurses in the same or similar locality and under similar circumstances. (Citations.)

6. A significant amount of time was spent during the hearing with testimony regarding whether certain hospital policies were in effect at the relevant times, whether Respondent was aware of such policies and had signed off on them, and whether, if Respondent failed to comply with such policies, that conduct constituted a deviation from the standard of care. As described in Legal Conclusion 5, above, the standard of care for a nurse is a community standard. It is not limited to a specific hospital or hospital policy. Although a failure to comply with a hospital policy may be viewed as a sign of negligence, it does not define negligence unless that conduct breaches the community standard. Thus, although it was found that Respondent was aware of the hospital policies, she would have been found grossly negligent even if she was not, or even if the hospital policies did not exist, because she was found to have committed extreme deviations from the standard of care within the nursing community, rather than just within the confines of MLK.

7. Business and Professions Code section 2761, subdivision (a) authorizes disciplinary action against a certified or licensed nurse for unprofessional conduct. That subdivision includes a non-exhaustive, non-exclusive list of acts and omissions which specifically constitute unprofessional conduct. Included in that list are both gross negligence and incompetence in carrying out usual certified or licensed nursing functions. (Bus. & Prof. Code, § 2761, subd. (a)(1).)

8. California Code of Regulations, title 16, section 1442 states:

> As used in Section 2761 of the [Business and Professions] code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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9. California Code of Regulations, title 16, section 1443 states:

> As used in Section 2761 of the [Business and Professions] code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

10. In her opening statement, Respondent's counsel referred to this case as a "witch hunt." In closing argument, she called it a "travesty." It is neither. The evidence amply established, by clear and convincing evidence to a reasonable certainty, that Respondent demonstrated gross negligence and incompetence, as defined by the above regulations, with respect to her care of patients W.W. and M.N., and that she falsified the hospital records of patient W.W. Because it was not alleged in the First Amended Accusation, her falsification of M.N.'s hospital record, by representing that she performed three restraint checks before she had arrived on the unit, is deemed a factor in aggravation rather than another cause for discipline.

11. Additional aggravating factors exist. Respondent acted intentionally with respect to falsifying both patients' records. Her misconduct with respect to both patients was extremely serious and resulted in patient harm[19].

12. Respondent criticized Complainant's witnesses for their review of only a portion of each patient's record, instead of all of the medical records. She argued that the witnesses could not be considered credible without having read all of the two charts. The argument was not persuasive. First, Respondent did not specify which documents should have been reviewed, what they contained, or how they may have changed the testimony or the outcome. Second, Respondent either had all of the medical records on her counsel table or had access to them via subpoena. Had any documents in those records that had not been reviewed by the witnesses contained exculpatory evidence, she could have impeached Complainant's witnesses with them or used them in her case in chief to develop her affirmative defenses. She did neither. "If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust." (Evid. Code, § 412.)

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[19] Patient harm need not occur for cause to exist to discipline a professional license. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1053, 236 Cal.Rptr. 526.) However, it may be considered as a factor in aggravation and for purposes of determining the nature and extent of the discipline to be imposed.

13. Respondent argued that M.N.'s records show a timeline on the last day of M.N.'s life that establishes not only her attentiveness to the patient, but a consistent stream of medical professionals who were in and out of the patient's room during the day. She is correct. However, the medical professionals were not in the room during either red alert, and Respondent's attentiveness during the day does not negate her failure to check and adjust the volume on the cardiac monitor, her failure to recognize M.N.'s abnormal readings on the cardiac monitor, or her failure to notify appropriate hospital personnel of an actual or potential problem with the monitor after M.N.'s death, in compliance with Dr. Chiou's order.

14. A significant amount of time was spent during the administrative hearing on the issue of Respondent's punctuality in reporting to work. No issue relating to her punctuality was alleged in the First Amended Accusation. It was asserted by Complainant in an apparent attempt to show that Respondent's misconduct was the result of her being otherwise occupied with outside activities such as her part-time work and studying for her nurse practitioner certification. Complainant did not prove a nexus between her misconduct and her outside activities. Further, such issues, including but not limited to, whether Respondent was counseled or reprimanded for her tardiness by her superiors, were irrelevant and are not considered in this decision. Respondent was required to act competently and within the standard of care, and she was required to keep true and accurate records regardless of her outside activities. She failed to do so. Although her reasons for her misconduct may have been relevant for purposes of mitigation or rehabilitation, those reasons were not established by the evidence.

15. Particularly troubling is the fact that Respondent fails to accept responsibility for her misconduct, and further fails to acknowledge she did anything wrong, even in the face of overwhelming evidence to the contrary, including major concessions from her own expert witness. The law does not require a respondent to demonstrate artificial acts of contrition. (*Calaway v. State Bar* (1986) 41 Cal.3d 743, 747-748.) However, when, as here, findings are made substantiating the allegations and the respondent chooses against offering any evidence that might diminish the degree of imposed discipline, a finding of either mitigation or rehabilitation cannot be made, or even inferred.

16. Respondent's acts of gross negligence and incompetence, and her deliberate falsification of hospital records, especially when taken in concert and in the absence of any evidence of mitigation or rehabilitation, evince an unfitness to practice registered nursing. Despite her otherwise laudable career, only license revocation can adequately protect the public health, safety, welfare and interest.

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ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

1. Registered Nurse License No. RN 417053, Nurse Practitioner Certification number 17022, and Nurse Practitioner Furnisher Certification No. 17022, issued to Respondent, Wilma Elaine Walker, are revoked.

2. Within 90 days of the effective date of this Decision, Respondent shall reimburse the Board the sum of $33,083.25 for its costs of investigation and prosecution.

DATED: August 3, 2009

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **WILMA ELAINE WALKER** 1136 Rose Walk Way Pasadena, CA 91103 Registered Nurse License No. RN 417053 Nurse Practitioner License No. NP 17022 Nurse Practitioner Furnisher License No. NPF 17022 Respondent.	Case No. 2008-101 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about January 1, 1987, the Board issued Registered Nurse License No. RN 417053 to Wilma Elaine Walker (Respondent). The Registered Nursing License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2009, unless renewed.

3. On or about November 21, 2006, the Board issued Nurse Practitioner License No. NP 17022 to Respondent. The Nurse Practitioner License will expire on May 31, 2009, unless renewed.

4. On or about October 15, 2008, the Board issued Nurse Practitioner Furnisher License No. NPF 17022 to Respondent. The Nurse Practitioner Furnisher License will expire on May 31, 2009, unless renewed.

JURISDICTION

5. This First Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

6. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

8. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

9. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . . .

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"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

10. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

11. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

12. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

SUMMARY OF FACTS

Patient W. W.

14. In about February, 2004, while employed as a registered nurse at the Martin Luther King/Charles R. Drew Medical Center (King/Drew), Respondent was assigned to care for Patient W.W. Patient W.W. was admitted for treatment of meningitis. From on or about February 12, 2004 to on or about February 17, 2004, King/Drew's pharmacy generated a daily Medication Administration Record (MAR) for Patient W.W., listing Gleevec, an anti-cancer medication, as one of the patient's medications, although there was no physician's order for Gleevec. On February 12, 2004 and February 13, 2004, other nurses caught the error by comparing the physician's orders with the MAR. On or about February 17, 2004, Respondent failed to verify the physician's order with the MAR and administered Gleevec to patient W.W.

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Respondent initialed Patient W.W.'s MAR, noting that she had reviewed the MAR against the physician's order and administered the drug to the patient.

Patient M.N.

15. On or about October 7, 2004, Respondent was assigned to King/Drew's ICU-B as the charge nurse. Patient M.N. was admitted to Respondent's unit under Respondent's care that day. Patient M.N. was hooked up to a cardiac monitor prior to Respondent's shift.

16. At 1120 hours, the monitor history for Patient M.N. revealed red alarms which continued until 1221 hours for low oxygen saturation ranging from 78% to 89% and tachycardia.

17. At 1613 hours, the monitor history for Patient M.N. revealed red alarms for extreme tachycardia. Those alarms continued until 1620 hours as the heart rate began to drift down. At 1623 hours, the monitor history revealed red alarms for asytole. The heart rate was recorded to be 39 beats per minute at 1623 hours, 17 beats per minute at 1625 hours, 0 beat at 1627 hours, 30 beats per minute at 1629 hours and 11 beats per minute at 1631 hours. The physician on duty walked by Patient M.N.'s bed at approximately 1631 hours and observed the low heart beat rate on the monitor, but noted the alarm did not sound. The physician initiated resuscitation measures and Patient M.N. expired at 1709 hours. These alarms went undetected because the volume was turned down such that the alarms were inaudible.

18. None of the alarmed events were documented by Respondent. Respondent documented that she checked the monitor alarms at 0800, 1000, 1200, 1400, 1600 and at 1800 hours. Respondent also documented at 1800 hours the following interventions "mouth care, patient position changed to supine, suctioning, equipment check, alarm checks for the cardiac monitor, and pulse oximeter." Respondent later crossed out the 1800 hours interventions and noted, "ERROR, pt expired at 1709."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence)

19. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code on the grounds of unprofessional conduct, in that Respondent committed acts of gross negligence and/or incompetence, within the meaning of California Code of Regulations, title 16, sections 1442, 1443 and 1443.5 involving the treatment of Patients W.W. and M.N. The circumstances are as described in paragraphs 14-18 above, which are incorporated herein by reference, and as follows:

Patient W.W.

a. On or about February 17, 2004, Respondent was grossly negligent in that she failed to compare Patient W.W.'s MAR with the physician's orders and administered the wrong medication.

b. Respondent was grossly negligent and incompetent in that she administered an anti-cancer drug, Gleevec to a patient who was being treated for meningitis.

Patient M.N.

c. On or about October 7, 2004, Respondent was grossly negligent in that she failed to check and did not ensure the volume on the cardiac monitor was turned up to an audible level.

d. Respondent was grossly negligent in that she failed to recognize the abnormal recorded events of Patient M.N. during her shift.

e. Respondent was grossly negligent in that she pre-documented observations and interventions at 1800 hours before their prescribed time and in advance to their occurrences.

g. Respondent was grossly negligent in that she failed to notify appropriate personnel about the volume of the monitor alarm.

h. Respondent was grossly negligent in that her documentation of Patient M.N.'s vital signs was inconsistent with the recorded events of the cardiac monitor.

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SECOND CAUSE FOR DISCIPLINE

(Falsified Hospital Records)

20. Respondent is subject to disciplinary action under sections 2761 and 2762, subdivision (e) of the Code on the grounds of unprofessional conduct, in that Respondent falsified hospital records. The circumstances are as described in paragraphs 14-19 above, which are incorporated herein by reference, and as follows:

Patient W.W.

a. On or about February 17, 2004, Respondent initialed Patient W.W.'s MAR, confirming that she had compared the MAR against the physician's orders for accuracy. Respondent did not accurately review patient W.W.'s MAR and administered a medication that had not been ordered by the patient's physician.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 417053, Nurse Practitioner License No. 17022, and Nurse Practitioner Furnisher License No. 17022 issued to Wilma Elaine Walker;

2. Ordering Wilma Elaine Walker to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 10/20/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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